Health Services
LOS ANGELES COUNTY

ATTACHMENT A

Los Angeles County – Department of Health Services

APPLICATION FOR NATIONAL SPECIALTY AND BOARD CERTIFICATION REIMBURSEMENT

*APPLICATION FORMS MUST BE SUBMITTED FOUR WEEKS BEFORE THE COURSE BEGINS
INCOMPLETE OR ILLEGIBLE FORMS WILL NOT BE PROCESSED

SECTION I. EMPLOYEE INFORMATION

Last Name		First Name			
Employee No.		Item No.		Dept No.	
Mailing Address					
Work Location/Area		Work Phone No.	( )		
Work Address					
Email Address (County)	( )	Cell Phone No.	( )		
Name of Program					

SECTION II. REIMBURSEMENT ELIGIBILITY

ATTACH COURSE DESCRIPTION

Title		Course No.		Units	
Start Date (MM\DD\YY)		End Date (MM\DD\YY)			
Course Description					

Course Title		Course No.		Units	
Start Date (MM\DD\YY)		End Date (MM\DD\YY)			
Course Description					

Total Fee	$

Date		Employee Signature	

SECTION III. TO BE COMPLETED BY SUPERVISOR / NURSE MANAGER

I recommend approval for this employee's application and certify that the employee meets the department's National Specialty and Board Certificate Reimbursement Policy guidelines (attendance standards, has passed the initial probationary period and has a current rating of competent or better on annual performance evaluation): □ YES □ NO

If NO, reason denied:			
Date		Nurse Manager or Supervisor Signature	
Payroll Title		Print Name	

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SECTION IV. TO BE COMPLETED BY FACILITY NURSE RECRUITMENT OFFICE OR NURSING ADMINISTRATION			
Employee Last Name		Employee First Name	
Reviewed and approved by Facility Nurse Recruiter or Authorized Personnel: □ YES □ NO			
If NO, reason denied:			
Date		Signature	
Payroll Title		Print Name	
Reviewed and approved by Chief Nursing Officer or Authorized Personnel: □ YES □ NO			
If NO, reason denied:			
Date		Signature	
Payroll Title		Print Name	